CORRESPONDENCE

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Performance of skin biopsies by general practitioners

SIR,—I fully support William F Whimster and Rosemary A Leonard's conclusion that all surgical specimens removed by general practitioners should be submitted for histopathological examination.[1] The study by Lorna J McWilliam and colleagues, however, underrepresents the results of other general practitioners.[2]

Rotherham district was a pilot site in the assessment of minor surgery in general practice,[3] and general practitioners were given intensive refresher courses and training sessions when necessary. Despite a similar case mix the results of 600 biopsies done in Rotherham since April this year show a substantial difference from those reported in Manchester (table). Also, in contrast to the findings of Hillan *et al*,[4] no general practitioner has submitted any specimen in the wrong fixative. These regional differences in quality indicate the urgent need to establish national standards for minor surgery in general practice and the necessity for audit.

An interesting additional finding in Rotherham has been substantial differences in the mean diameter of lesions excised by general practitioners, dermatologists, and general surgeons (mean (SD) 4·8 (5·4), 8·8 (5·3), and 15 (8·0) mm respectively). It is hard to avoid the conclusion that many excisions by general practitioners are done for cosmetic rather than medical reasons, especially with some lesions below 1 mm in diameter.

As well as being important in diagnosis, clinical management, and audit histopathological examination is important for avoiding medicolegal action. As a practising dermatopathologist; I have been involved in four such cases over the past 10 years, in which malignancy recurred after the initial discarding of the specimen.

Whimster and Leonard correctly highlight the need to submit surgical specimens to accredited laboratories. With the advent of the new diploma in dermatopathology of the Royal College of Pathologists, however, perhaps in the future fundholding general practitioners will wish to submit specimens only to histopathologists with this qualification. Whimster and Leonard also state that pigmented and suspected malignant lesions should probably be off limits to general practitioners unless they have had dermatological training. Surely, however, no general practitioner should be accredited for minor surgery without such training and skill.

An easy move would be to make payment for minor surgery depend on submission of specimens for histopathological examination.

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1 Whimster WF, Leonard RA. Surgical pathology in general practice. *BMJ* 1991;**303**:1149-50. (9 November.)
2 McWilliam LJ, Knox F, Wilkinson N, Oogarah P. Performance of skin biopsies by general practitioners. *BMJ* 1991;**303**:1177-9. (9 November.)
3 O'Cathain A, Brazier JE, Milner PC, Fall M. Cost effectiveness of minor surgery in general practice. *Br J Gen Pract* (in press).
4 Hillan KJ, Johnson CP, Morton R. Effect of general practitioner contract on referral of specimens for histological examination. *BMJ* 1991;**303**:1180. (9 November.)

SIR,—Statements to the effect that all skin biopsy specimens excised by general practitioners should be sent for histopathological diagnosis appear in each of four articles published in one issue.[1-4] We question the validity of this policy.

The only patients likely to come to any substantial harm are not included in the studies—namely, patients in whom cancers are inadequately excised and for whom no specimen is sent for histopathological examination. Every patient in these studies had the correct diagnosis made histopathologically and should have received the correct treatment. The patients in these studies are likely to have been highly selected and in no way representative of all patients undergoing minor surgery in general practice. Lorna J McWilliam and colleagues acknowledge that general practitioners apply systematic criteria to the decision to send a specimen.[2] General practitioners would normally send a specimen if they considered that there was even a slight chance of malignancy.

Mortality from skin cancer also depends on the number of patients who fail to be seen by any doctor. The fact that general practitioners' workload relating to skin cancer has increased so greatly suggests that this number may be falling.

It is unwise to conclude that the total number of cancers being detected is falling, even if general practitioners occasionally fail to diagnose cancers that they see. Furthermore, the figure of 80% of cancers being inadequately excised by general practitioners, widely quoted in the lay press does not distinguish cancers that may be fatal from non-fatal tumours. Out of 78 cancers in McWilliam and colleagues' study, only one was a melanoma. The other cancers may recur locally if excision is inadequate but are extremely unlikely to be fatal.

We believe that, although McWilliam and colleagues have identified a potential problem, preventing general practitioners from using any discretion about whether a lesion could be malignant is not the most rational response. The known additional cost of histopathological diagnosis in every case must be justified by well founded evidence of health benefits.[5] We are engaged in research to establish just how many potentially serious cancers are currently being missed by general practitioners because they do a biopsy but do not send a specimen for histopathological examination. If we find that an appreciable number are being missed several strategies are possible. It may be cost effective to improve training of general practitioners and perhaps link this to accreditation. Performance could also be audited. These alternatives should be considered before it is concluded that the only solution is the expensive and time consuming option of sending all specimens for histopathological examination.

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1 Whimster FW, Leonard RA. Surgical pathology and general practice. *BMJ* 1991;**303**:1149-50. (9 November.)
2 McWilliam LJ, Knox F, Wilkinson N, Oogarah P. Performance of skin biopsies by general practitioners. *BMJ* 1991;**303**:1177-9. (9 November.)
3 Williams RB, Burdge AH, Lewis Jones S. Skin biopsy in general practice. *BMJ* 1991;**303**:1179-80. (9 November.)
4 Hillan KJ, Johnson CP, Morton R. Effect of general practitioner contract on referral of specimens for histological examination. *BMJ* 1991;**303**:1180. (9 November.)
5 O'Cathain A, Brazier JE, Milner PC, Fall M. Cost effectiveness of minor surgery in general practice: a prospective comparison with hospital practice. *Br J Gen Pract* (in press).

Results (expressed as percentages) of minor surgery done by general practitioners and hospital doctors in Rotherham district compared with Manchester

	General practitioners		Hospital	
	Rotherham	Manchester	Rotherham	Manchester
Incorrect clinical diagnosis	42	59	17	38
Malignancy considered to be benign clinically	8	71	2	10
Inadequate excision	5	36	3	16
Inadequate clinical details	1	42	2	41
Inadequate specimens	0·1	3·4	0·1	0·6

SIR,—Before opportunity is taken to berate general practitioners for their apparent lack of skill in performing skin biopsies[1-4] the results of minor operations in general practice and hospital practice should be compared by analysis of results obtained by general practitioners trained in minor surgery and surgeons in training.

We were dismayed to read that only one third of specimens excised in hospital were sent for histological examination.[3] Audit of our minor operations register for 1987 to 1991 shows that an average of 82% of specimens excised were sent for histological examination (table). The only